

MEDICAL POLICY STATEMENT

Wisconsin Marketplace

Policy Name & Number	Date Effective
Neonatal Discharge Criteria-WI MP-MM-1628	12/01/2024-04/30/2025
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject.....	2
B. Background.....	2
C. Definitions	2
D. Policy	2
E. Conditions of Coverage.....	4
F. Related Policies/Rules.....	4
G. Review/Revision History.....	4
H. References.....	4

A. Subject
Neonatal Discharge Criteria

B. Background

Infants who require neonatal admission remain at increased risk for morbidity and mortality following discharge. These infants require comprehensive discharge planning to ensure a smooth transition from the neonatal intensive care unit (NICU) and reduce morbidity and mortality after discharge.

Despite the inability to predict the exact timing of a NICU discharge, discharge planning should begin at NICU admission in an effort to avoid overwhelming parents and hospital staff. This planning will aid in minimizing discharge delays and will promote safe and healthy discharges to home.

Discharge may be appropriate when the establishment of physiologic competencies, including, but not limited to, thermoregulation, feeding, respiratory control, and stability regardless of weight or corrected gestational age, have been achieved.

C. Definitions

- **Acceptable Bilirubin Level** – Defined per American Academy of Pediatrics (AAP) guidelines.
- **Bilirubin** – Blood test to measure liver function.
- **Car Seat Test Eligibility** – An infant tolerance test for sitting usually occurring < 37 weeks gestation or if at risk for respiratory compromise.
- **Feeding Difficulties** – Minimal or no ability to feed orally.
- **Oral (PO) Feeding** – By mouth feeding.
 - **Adequate PO Feeding** – Ingesting sufficient oral feeding to support adequate or appropriate growth.
- **Stable Body Temperature** – Ability to maintain body temperature > 36.4° C axillary while clothed in an open bed/crib.

D. Policy

- I. Common Ground Healthcare Cooperative (CGHC) considers neonatal discharge medically appropriate for **non-technology dependent** infants when **ALL** of the following clinical criteria are met:

A. Thermoregulation Stability

1. Infant demonstrates the ability to maintain normal body temperature while clothed in an open crib. Up to 48 hours of stable body temperature is typically adequate for infants born < 37 weeks gestation.
2. 12 hours of stable body temperature is adequate for infants born ≥ 37 weeks.
3. For infants placed in an isolette solely for the purpose of phototherapy and not thermoregulation, additional observation is not required once treatment is completed.

- B. Cardio-Respiratory Stability
 - 1. Infant is stable on room air after discontinuation of oxygen therapy for up to 48 hours.
 - 2. If infant was on caffeine, the infant has been observed for apnea for 5 days off caffeine.
 - 3. Event countdown
 - a. The infant has not had any clinically significant apnea/bradycardia/desaturation (A/B/D) episodes for 5-7 days. An event is considered clinically significant if the infant required stimulation.
 - b. The infant has not had any self-resolved B/D events in the last 48 hours.
 - c. Isolated bradycardia events that are associated with feeding should not delay discharge as these are observed events with a known cause
 - 4. Infant passed car seat test, if applicable.
 - C. Feeding and Adequate Weight Gain
 - 1. Infant demonstrates adequate PO feeding by bottle or breast for up to 48 hours.
 - 2. Overall weight gain is adequate, as expected for gestational age and day of life.
 - D. Bilirubin
 - 1. Acceptable level based on hours of life per AAP Bilitool (Bilitool.org).
 - 2. Risk factors include the following:
 - a. gestational age < 38 weeks (risk increases with the degree of prematurity)
 - b. albumin < 3.0 g/dL
 - c. isoimmune hemolytic disease (ie, positive direct antiglobulin test), G6PD deficiency, or other hemolytic conditions
 - d. sepsis
 - e. significant clinical instability in the previous 24 hours
- II. CGHC considers neonatal discharge medically appropriate for **technology-dependent** infants when **ALL** of the following clinical criteria are met:
- A. Cardio-Respiratory Stability
 - 1. Infant is stable, but has one or more of the following conditions:
 - a. Bronchopulmonary dysplasia (BPD) and is on low flow nasal cannula at any oxygen concentration with a flow rate of ≤ 0.5 LPM (liters per minute).
 - b. Infant has tracheostomy and requires positive pressure ventilation. Ventilator settings are stable and fraction of inspired O₂ is < 40% utilizing a home ventilator.
 - B. Feeding and Adequate Weight Gain
 - 1. Infant is stable but has 1 of the following conditions:
 - a. Infant has feeding difficulties and is dependent on gastrostomy and/or nasogastric tube feedings. Appropriate home health care and family teaching has been completed.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	09/25/2024	New policy. Approved at Committee.
Date Revised		
Date Effective	12/01/2024	
Date Archived	04/30/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. American Academy of Pediatrics Committee on Fetus and Newborn. Hospital discharge of the high-risk neonate. *Pediatrics*. 2008;122(5):1119-1126. doi:10.1542/peds.2008-2174
2. American Academy of Pediatrics Committee on Infectious Diseases; American Academy of Pediatrics Bronchiolitis Guidelines Committee. Updated guidance for palivizumab prophylaxis among infants and young children at increased risk of hospitalization for respiratory syncytial virus infection. *Pediatrics*. 2014;134(2):415-420. doi:10.1542/peds.2014-1665
3. Benitz WE; Committee on Fetus and Newborn; American Academy of Pediatrics. Hospital stay for healthy term newborn infants. *Pediatrics*. 2015;135(5):948-953. doi:10.1542/peds.2015-0699
4. Brooten D, Kumar S, Brown LP, et al. A randomized clinical trial of early hospital discharge and home follow-up of very-low-birth-weight infants. *N Engl J Med*. 1986;315(15):934-9. doi:10.1056/NEJM198610093151505
5. Buchman AL. Complications of long-term home total parenteral nutrition: their identification, prevention and treatment. *Dig Dis Sci*. 2001;46(1):1-18. doi:10.1023/a:1005628121546
6. Casiro OG, McKenzie ME, McFadyen L, et al. Earlier discharge with community-based intervention for low-birth-weight infants: a randomized trial. *Pediatrics*. 1993;92(1):128-134. doi:10.1542/peds.92.1.128
7. Davies DP, Haxby V, Herbert S, et al. When should pre-term babies be sent home from neonatal units? *Lancet*. 1979;1(8122):914-915. doi:10.1016/s0140-6736(79)91386-2
8. Eichenwald EC; AAP Committee On Fetus And Newborn. Apnea of prematurity. *Pediatrics*. 2016;137(1):e20153757. doi:10.1542/peds.2015-3757
9. Garg M, Kurzner SI, Bautista DB, et al. Clinically unsuspected hypoxia during sleep and feeding in infants with bronchopulmonary dysplasia. *Pediatrics*. 1988;81(5):635-642. doi:10.1542/peds.81.5.635
10. Groothuis JR, Rosenberg AA. Home oxygen promotes weight gain in infants with

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

- bronchopulmonary dysplasia. *Am J Dis Child*. 1987;141(9):992-995.
doi:10.1001/archpedi.1987.04460090069028
11. Halliday HL, Dumpit FM, Brady JP. Effects of inspired oxygen on echocardiographic assessment of pulmonary vascular resistance and myocardial contractility in bronchopulmonary dysplasia. *Pediatrics*. 1980;65(3):536-540.
doi:10.1542/peds.65.3.536
12. Jefferies AL; Canadian Paediatric Society; Fetus and Newborn Committee. Going home: facilitating discharge of the preterm infant. *Paediatr Child Health*. 2014;19(1):31-42. doi:10.1093/pch/19.1.31
13. Kemper AR, Newman TB, Slaughter JL, et al. Clinical practice guideline revision: management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatr*. 2022;150(3):e2022058859. doi:10.1542/peds.2022-058859
14. Moyer-Mileur LJ, Nielson DW, Pfeffer KD, et al. Eliminating sleep associated hypoxemia improves growth in infants with bronchopulmonary dysplasia. *Pediatr*. 1996;98(4 Pt 1):779-783. doi:10.1542/peds.98.4.779
15. Muchowski KE. Evaluation and treatment of neonatal hyperbilirubinemia. *Am Fam Physician*. 2014;89(11):873-878. Accessed June 3, 2024. www.aafp.org
16. Ortenstrand A, Waldenström U, Winbladh B. Early discharge of preterm infants needing limited special care, followed by domiciliary nursing care. *Acta Paediatr*. 1999;88(9):1024-1030. doi:10.1080/08035259950168568
17. Ortenstrand A, Winbladh B, Nordström G, et al. Early discharge of preterm infants followed by domiciliary nursing care: parents' anxiety, assessment of infant health and breastfeeding. *Acta Paediatr*. 2001;90(10):1190-1195.
doi:10.1080/080352501317061639
18. Pinney MA, Cotton EK. Home management of bronchopulmonary dysplasia. *Pediatrics*. 1976;58(6):856-859. Accessed June 3, 2024.
www.pubmed.ncbi.nlm.nih.gov
19. Schneiderman R, Kirkby S, Turenne W, et al. Incubator weaning in preterm infants and associated practice variation. *J Perinatol*. 2009;29(8):570-574.
doi:10.1038/jp.2009.54
20. Sekar KC, Duke JC. Sleep apnea and hypoxemia in recently weaned premature infants with and without bronchopulmonary dysplasia. *Pediatr Pulmonol*. 1991;10(2):112-116. doi:10.1002/ppul.1950100213
21. Smith VC, Stewart J. Discharge planning for high-risk newborns. UpToDate. Updated April 10, 2023. Accessed June 3, 2024. www.uptodate.com
22. Zecca E, Corsello M, Priolo F, et al. Early weaning from incubator and early discharge of preterm infants: randomized clinical trial. *Pediatr*. 2010;126(3):e651-e656. doi:10.1542/peds.2009-3005

Independent medical review – 12/27/2021